

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 03/23/01?
 - b. The request was received on 02/04/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution dated 02/27/02
 - b. HCFAs
 - c. EOBs
 - d. Reimbursement data (EOBs from other carriers)
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and Response to a Request for Dispute Resolution dated 03/13/02
 - b. Reimbursement data (DME catalog – Sammons Preston, 1999)
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 03/07/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 03/09/02. The response from the insurance carrier was received in the Division on 03/18/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: per letter dated 02/27/02
"The disputed issue is that the Carrier has paid \$39.00 for the cervical pillow stating no MAR reduced to fair and reasonable. We resubmitted the claims to the Carrier requesting additional payment. The Carrier denied the request for additional payment stating denial after reconsideration no invoice was submitted."

2. Respondent: per letter dated 003/13/02
“(Respondent) based its rate on the Sammons Preston durable medical equipment catalog, page 375 (Exhibit 2), and adjusting this price in accordance with the Rockport Contract to arrive at a reimbursement of \$39.00. (Respondent) normally adds 20% to the price listed in the DME catalog, bringing the reimbursement to \$46.80. However, the contract calls for a reduction of 20%, resulting in payment of \$39.00, the same amount paid...”

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only date of service eligible for review is 03/23/01.
2. The carrier’s EOB has the denial “M – REDUCED TO FAIR AND REASONABLE.”
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
03/23/01	E1399 mediflow waterbase cervical pillow	\$95.00	\$39.00	M	DOP	Texas Workers' Compensation Act & Rules, Sec. 413.011 (d), Rule 133.304 (i); MFG, GI (VI)	Due to the fact there is no current fee guideline for the DME provided, the Medical Review Division has to determine based on the parties' submission of information, what represents fair and reasonable reimbursement. The carrier's reimbursement is based on the Sammons Preston, 1999 catalog price. The provider has submitted several EOBs from other carriers that show the provider has been reimbursed the billed amount of \$95.00. However, recent SOAH decisions have placed minimal weight on EOBs when documenting fair and reasonable reimbursement. The willingness of some carriers to reimburse at or near 100% of the billed charges does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (d), of the Texas Labor Code. The EOBs provide no evidence of amounts paid on behalf of managed care patients or on behalf of other non-workers' compensation patients with an equivalent standard of living. Based on the documentation available for review, no additional reimbursement is recommended
Totals		\$95.00	\$39.00				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 3rd day of June 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.